Special Needs Alert Program

SNAP-911

Office of Emergency Medical Services,
Emergency Medical Services and Preparedness Section
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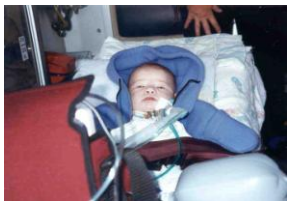
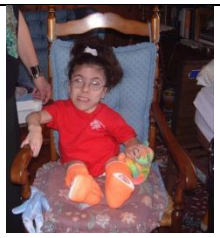
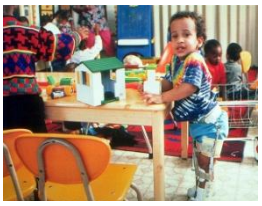

What is the Special Needs Alert Program?

The Special Needs Alert Program (**SNAP-911**) recognizes children with special healthcare needs for Emergency Medical Services (EMS) providers. It is a pre-hospital notification program for any child who has special emergency care needs. When a child is registered in **SNAP-911**, EMS providers are alerted that the call is for a SNAP-911 child. If medical information is available, providers will be able to give appropriate emergency care for the child and reduce the level of stress often experienced by the family when there is an emergency. In the event of a 911 call, the emergency medical service team, together with the family will determine the child's most important needs.

Who May Enroll?

Any child (0-21 years of age) with special healthcare needs may enroll. This includes, but is not limited to children with developmental delays, behavioral health problems, physical disabilities, special medical technology or equipment, seizure disorder, severe allergies, hearing loss, vision loss, diabetes, Autism, Down syndrome, or Cerebral Palsy. This also includes premature and low birth weight babies. No family will be excluded if they feel they will benefit from **SNAP-911**.

Participation is strictly on a voluntary basis. You may cancel enrollment at any time. SNAP enrollment is free of charge.

How to Enroll Your Child

Call the Emergency Medical Services for Children (EMSC) Office at **302-223-1355.** Ask to enroll in the **SNAP-911** program.
Down the enrollment instructions and forms via the SNAP website.
http://www.dhss.delaware.gov/dph/ems/emscsnap.html
Online enrollment is available at the following website.
Delaware Emergency Preparedness Voluntary Registry for citizens who have special needs website,
http://www.de911assist.delaware.gov/

Let's look at a SNAP-911 call to 911

When your child needs emergency medical services, dial 911. Describe the type of emergency and your location. Tell the dispatcher that your child is a SNAP-911 child. EMS may review the child's special health information and be prepared prior to arrival at the scene of an emergency.

Easter Seals DISABILITY SERVICES

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

SNAP

Special Needs Alert Program (SNAP-911)

Dear Parent or Guardian,

To enroll your child in the Special Needs Alert Program (SNAP-911), please complete the following forms:

- The Enrollment Form
  - Please complete all information requested. If the question is not applicable, please enter N/A.
  - Please remember to notify SNAP-911 of any changes or updates to your child's enrollment information (i.e. address, telephone, school or daycare changes, or email address changes)
  - Please complete the Special Instructions located in the Medical Information Section. What special instructions will the Emergency Medical Services provider need to treat this child?

- The Consent Form.
  - The Consent Form must be signed and witnessed. The witness may be anyone over the age of 18 and the form does not need to be notarized.
  - The Consent Form must be updated annually. You will be notified when the annual update is due. If you do not provide the annual update, you may be removed from the program.

- The Emergency Information Form
  - The Emergency Information Form is a more in-depth medical form developed by the American Academy of Pediatrics for family use in the event of an emergency. Once completed, a copy of the form should be kept with the child at all times in case of emergency. In the event of an emergency or hospitalization, you can share this form with medical care providers.
  - This form should be completed and signed by your child's primary care or specialty physician and updated as changes in information occur.

Once enrolled, the enrollee will not be removed from the Special Needs Alert Program, even after age 21, except if requested information is not updated annually.

Mail the original forms to me at the address on the bottom of this sheet.

Please call me if you have any questions or concerns. You will receive a call from our office when your paperwork is processed.

Thank you for enrolling your child in the Special Needs Alert Program.

Sincerely,
Beth Appenzeller MacDonald
SNAP Coordinator
beth.macdonald@state.de.us
Phone: 302-223-1355 Fax: 302-223-1330

SNAP-911 #

SPECIAL NEEDS ALERT PROGRAM ENROLLMENT FORM

Child's Name:	Name Child Responds To:	
Date of Birth:		
Parent(s)/Guardian(s):		
Home Phone:	Work Phone:	
Cell Phone:	Email:	
MEDICAL INFORMATION		
Primary Medical Issue:		
Other Medical Issues/Diagnoses:		
Technology/Assisted devices:		
Special Instructions:		
HOME INFORMATION		
Street Address:		
City:	Zip:	County:
Home Description:		
Best Entrance for EMS Responders:		
Child's room location:		
Local Fire Department/Ambulance Service:		
Caregiver's Name (if other than parent/guardian):		
Caregiver's Phone:		
CHILD CARE/SCHOOL/DAY PROGRAM INFORMATION		
Child Care/School/Day Program:		
Street Address:		
City:	Zip:	County:
Local Fire Department/Ambulance Service:		

FOR INTERNAL USE ONLY		
Date of Application:	☐ Technology	☐ Medication
Date of Enrollment:	☐ Non-Technology	☐ Behavioral
Date of Home Visit:	Agency:	

DELAWARE
EMERGENCY MEDICAL SERVICES FOR CHILDREN

Consent for Enrollment in the Special Needs Alert Program (SNAP-911)

The Delaware Emergency Medical Services for Children program for Children with Special Healthcare/Medical Needs will keep all information provided on the Emergency Information Form and the Home Visit Form confidential, pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and effective Nationwide as of April 14, 2003.

Each Ambulance Service throughout the State of Delaware is required to present you with a Notice of their operation's Privacy Practices, as well as explain to you your rights under the Federal HIPAA laws and guidelines when visiting your home to obtain the above-referenced information for this program. In addition, all emergency medical personnel involved in responding to a medical emergency regarding your child are required to follow all privacy practices and stipulations in place, and cannot discuss, or disseminate in any form, any Protected Health Information (PHI) regarding your child, unless it is imperative to administering care required within the scope of their medical duties where your child is concerned.

By signing below, you acknowledge understanding that the information provided on the attached Enrollment Form may be shared with emergency medical field responders to aid them in providing the necessary emergency medical care to your child and that you have received a copy of the local EMS agency privacy practices.

As a result of the form being used to provide a more complete medical record for your child, there is a potential for this protected health information to be redisclosed to other non-HIPAA covered entities.

Failure to sign this form will not ever result in denial of normal processing of emergency calls or denial of any medically necessary emergency treatment. Please feel free to contact the Ambulance Service at _____, the County EMS Agency at _____or the Emergency Medical Services for Children program in the Division of Public Health 302-233-1355 for any questions about the consent form or the SNAP.

By signing below, I give permission to share the Enrollment Form with necessary emergency medical staff so that they may provide all necessary emergency medical care to my child. I also acknowledge that I have received a copy of this completed consent form and local EMS agency privacy practices. I understand that I may revoke this statement in writing at any time, except to the extent that the organization named above has already taken action on this authorization. To revoke this statement notify in writing your local county EMS agency stating that you wish to withdraw your child from the "Special Needs Alert Program." Include your correspondence to the county EMS agency: the name of the child, the date of birth and the address.

_____	_____	_____
Parent/Guardian (Print Name) or Legal Custodian	Parent/Guardian (Signature) or Legal Custodian	Date

_____
Relationship to the child

_____	_____	_____
Witness (Print Name)	Witness (Signature)	Date

This Consent for Enrollment is effective for one year from the date of signature. A new consent and updated health forms will be required to continue in the Special Needs Alert Program after one year.

Emergency Information Form for Children With Special Needs

Patient ID

Today's Date:	Who is completing this form? You must confirm consent to use this form		
Your Name:	Is this the new form or just an update?	☐ Update	☐ New
CONSENT REQUIRED I (above named person) confirm that parent/ guardian consents to the use of this form		☐ **Consent**	
Patient's Name	Nickname		
Birthdate	Address		
Primary language	Parent/guardian name		
Contact phone Home	Emergency contact name		
Contact phone Work	Emergency contact number		
Contact phone Cell			

Facilities & Providers

Care Provider	Provider's name	Specialties	All contact phone numbers (E-mail option)	Fax
Primary care				
Specialist-1				
Specialist-2				
Specialist-3				
Specialist-4				
Specialist-5				
Others				
Primary Pharmacy (branch, phone)				
Anticipated primary emergency department				
Anticipated tertiary care center				

Clinical Baseline

Diagnoses/problem list (list all) starting with most important
Baseline physical findings
Baseline vital signs
Baseline neurologic status
Immunologic competency status
Synopsis of clinical status
Medications (doses, purpose)
Antibiotic prophylaxis (drug, dose, indication)
Significant baseline lab/imaging/diagnostic studies
Prostheses, appliances, advanced technology devices, life support
Allergies: Medications, foods, substances to be avoided and why
Advanced directives (include date of last review) Procedures to be avoided and why

ED Management

Describe common presenting problems/findings		Suggested studies	Treatment recommendations
Problem-1			
Problem-2			
Problem-3			
Problem-4			
Problem-5			
Problems-other			

Comments on child, family, or other specific medical issues

Immunizations

DPT dates	Varicella status
Dtap dates	Hep B dates
OPV or IPV dates	Hep A dates
MMR dates	Meningococcal (Specify which one if possible)
HiB dates	TB status
Pneumococcal-7	HP virus
Other	Other

Disaster Planning & Drills

Check or enter at least two of the most likely disasters that could affect this patient

☐ Power failure	☐ Fire, forest fire
☐ Hurricane	☐ Infrastructure (roads, communication) damage
☐ Tornado	☐ Shelter structure damage
☐ Earthquake	☐ Food and water supply compromise
☐ Flood	☐ Medication, supplies, equipment compromises
☐ Tsunami	☐ Nuclear radiation accident (fallout, meltdown, contamination, detonation, etc.)
☐ Blizzard	☐ Explosion/blast
☐ Avalanche	☐ Other (e.g., terrorism, biological accident, chemical accident, other weather event)
☐ Land/mud slide	
Other (describe)	Other (describe)

Disaster drills reviewed or practiced with patient. Documentation of completed drills and planned dates for future drills.

Date	Disaster type	Example drills: verbal review, Paper review, Table top model, Computer simulation, Hand on practice, Equipment review, In home review, Alternate electrical power, Electric generator use	Describe type of drill

Medical caregiver or physician's Name: (Print)	**Medical caregiver or physician's signature:**	**Date:**

American College of Emergency Physicians®

American Academy of Pediatrics

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